OF SOUTH JERSEY
Advanced
PHYSICAL THERAPY
Specializing in Sports Medicine & Geriatrics

856-728-4100
www.advancedphysicaltherapyofsouthjersey.com · rob.romalino@advancedphysicaltherapyofsouthjersey.com

Patient Information:

Last Name:_____ First Name_____

Date of Birth_____

SS#:____-____-_____ **(Required For Billing Purposes)**

****If Patient is a minor, Parent's Name & Social Security Number are required****

_____

Home Address:_____

City:_____ State:_____

Zip Code_____ Phone #: ( )_____-_____

Emergency Contact Name/Phone#_____

Patient's Employer_____

Employer Address & Phone #_____

Insurance Information:

Insurance Co. Name: _____ Policy #_____

Address_____ City: _____

Insured's Name: _____

Consent To Treat & Release of Information: (Must Be Signed & Dated)

I understand that I have been referred for rehabilitative treatment and care to Robert J Romalino PT, PC DBA: Advanced Physical Therapy of South Jersey. Advanced Physical Therapy of SJ will provide a comprehensive evaluation and prescribe an individual treatment plan based on their evaluation. I understand that I have the right to ask and have any questions answered prior to receiving any treatment including any risks or alternatives to the treatment plan that will be prescribed for me by my therapist. By signing this agreement, I consent to have Advanced Physical Therapy of South Jersey provide treatment and care as prescribed by my physician and/or recommended by my therapist. I authorize the release of medical information to my physician (s) and/or to my insurance carrier in order to process any claims.

_____ _____

Signature of Patient/Guardian **Date**

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Advanced Physical Therapy Office Policy:

I hereby understand and agree to accept responsibility for the following policies set in place by Advanced Physical Therapy.

1) I acknowledge this office requires ***All*** patients to provide a credit card to be kept on file. Failure to provide our office with a current card will result in the cancellation of any future appointments.

2) I acknowledge that I am required to provide this office with ***24-hour*** notice to cancel or reschedule an appointment, otherwise a $25.00 fee per occurrence will be charged to the credit card that I have provided at the discretion of the office.

3) I acknowledge that I am responsible for providing ***All*** insurance coverage & immediately notifying our office of any changes in such coverage.

4) I acknowledge this office will only verify the insurance policy I have provided is active. I understand it is ***my responsibility*** to know and understand my coverage and if I have questions regarding the specifics of my coverage it is best to contact the insurance carrier directly.

5) I acknowledge that this office does not guarantee coverage or payment for services provided. Determination of payment will be made once the claim has been received and processed by the insurance carrier. In the event a claim is denied, we will make every attempt on your behalf to get the claim paid. However, if your claim is denied, you are responsible for payment in full.

6) If you received treatment for injuries sustained during a slip and fall or motor vehicle accident and are represented by an attorney, you are still responsible for any co-payments, co-insurance and/or deductibles to be paid within ***30 days*** of receiving our invoice. We will not wait for your case to be settled to receive payment for services provided.

7) Invoices are mailed approximately the 1st of the month. The balance is due by the end of the current month unless a payment arrangement has been made with the billing department. Payments should be mailed to 1035 North Black Horse Pike Suite 5 Williamstown, NJ 08094. Failure to make a payment will result in a ***$25.00 late fee per month.*** Any patient account with a balance greater than $250.00 will require immediate payment to continue therapy OR the credit card you provided will be charged.

8) In the event a payment is not made within a timely manner, you are authorizing our office to charge the credit card of file for the amount due including any late fees associated on the account. Your credit card will be held securely on an electronic file.

9) In the event we are unable to process your credit card for payment, you understand that you are financially responsible for the payment of the bill and any fees that are incurred (i.e., administrative expenses, appearance fees, collection agencies or small claims court fees) to collect such debt.

I have read and understand the above policies and agree to all the terms and conditions.

Signature of Patient/Guardian **Date**

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Credit Card Authorization Form

This office has instituted a new policy effective immediately. ***Every patient will be required to provide a credit card to keep on file.*** Robert J Romalino PT, PC DBA: Advanced Physical Therapy of South Jersey will process the credit card payments as a secure and convenient method of payment for the portion of services that your insurance doesn't cover for which you are liable. We will be strictly enforcing the 24-Hour Cancellation/No Show Policy. In the event an appointment is missed or cancelled without proper notice, you are authorizing our office to charge the $25.00 fee at our discretion that you have provided.

Please note, you will receive a monthly invoice in the first week of the month for claims that have been processed by the insurance carrier. You will have until the last day of the current month to make a payment. Any patient account with a balance greater than $***250.00*** will require an immediate payment to continue therapy OR the credit card you have provided will be charged.

I _____, authorize Robert J Romalino PT, PC DBA: Advanced Physical Therapy of South Jersey to collect my credit card information and securely store my card on file.

I agree Robert J Romalino PT, DBA: Advanced Physical Therapy of South Jersey may charge my credit card on file for any outstanding balance on my account after 30 days. This authorization relates to all balances not covered by my insurance company for services provided by Robert J Romalino PT, PC DBA: Advanced Physical Therapy of South Jersey. This could be amounts resulting from balances related to co-payment, deductible, co-insurance, non-covered services, or denials but is not limited to these scenarios.

I understand that this form is valid until I give a 30-day written notice to cancel the authorization. Written notice must be submitted to Robert J Romalino PT, PC DBA: Advanced Physical Therapy of South Jersey, 1035 North Black Horse Pike Suite 5 Williamstown, NJ 08094.

I certify that I am an authorized user of this credit card and that I will not dispute the payment with the credit card company so long as the transaction corresponds to the terms indicated on this form.

Patient Name/Guarantor: _____

Card Holder's Name: _____

Card Number: _____

Expiration Date: _____ Cardholder Zip Code: _____

_____ _____

Cardholder Signature **Date**

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Patient Name: _____ ***Date:*** _____

Date of your next physician's visit: _____

1. *Date of Onset/Injury*: _____
2. *Have you ever had these symptoms before?* _____
3. *Pain Level (0-10) Now*: ____ *Worst 24 Hrs.*: ____ *Best Level Past 48 Hrs*____
4. *Check which applies to your current condition*:

_____ *Work Related* _____ *Recurrence of Previous Injury*

_____ *Injury Related to a fall* _____ *Motor Vehicle Accident*

_____ *Injury Related to Lifting* _____ *Cause Unknown*

_____ *Athletic/Recreational Injury* _____ *Other:* _____

Have you had a related surgery? Yes No if female, are you pregnant Yes No

Do you have any Metal Implants Yes No Do you have a Pacemaker? Yes No

Do you have a history of Seizures? Yes No Do you have any Allergies Yes No

Do you have, or have you had any of the following:

Diabetes	Yes	No	Hypoglycemia	Yes	No
Chest Pain/Angina	Yes	No	Arthritis	Yes	No
High Blood Pressure	Yes	No	Osteoarthritis	Yes	No
Hernia	Yes	No	Cancer	Yes	No
Heart Attack	Yes	No	Dizziness/Fainting	Yes	No
Fractures	Yes	No	Stroke	Yes	No
Surgeries	Yes	No	Rheumatic Arthritis	Yes	No
Asthma	Yes	No	Other Problems	Yes	No

_____ _____

Signature of Patient (guardian, spouse etc.) **Date**